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STATE OF NEW JERSEY
DEPARTMENT OF LAW & PUBLIC SAFETY
DIVISION OF CONSUMER AFFAIRS
BOARD OF NURSING

IN THE MATTER OF THE SUSPENSION OR REVOCATION OF THE LICENSE OF	:	Administrative Action
ANGELINE T. CHUA, R.N. **License # 26NR06502600**	:	**CONSENT ORDER**
TO PRACTICE NURSING IN THE STATE OF NEW JERSEY	:	

This matter was opened to the New Jersey State Board of Nursing ("Board") upon receipt of a Medical Malpractice Payment Report, dated August 16, 2012, which indicated that Atlanticare Regional Medical Center paid $240,000 on behalf of Angeline T. Chua, R.N. ("Respondent"). The settlement, finalized on or about March 9, 2012, resolved a claim arising out of Respondent's alleged misconduct which occurred on July 27, 2007. On January 3, 2013, the Board issued a Demand for Written Statement Under Oath and Respondent replied, with the assistance of counsel, on January 21, 2013.

A review of available information reveals that a 42 year-old patient was admitted to Atlanticare Regional Medical Center on July 27, 2007. At approximately 6:00 p.m. the attending physician ordered basic metabolic panel tests ("BMP") as the patient was experiencing slurred speech and confusion. The physician asked to be contacted when the test results were received. Subsequent to the physician's orders, Respondent was assigned to the patient during her overnight shift which lasted from 7:00 p.m. until 7:00 a.m.

The BMP was performed at 9:00 p.m. and the results were available at 10:50 p.m. The results revealed elevated glucose, BUN (blood urea nitrogen), creatine, and potassium levels in addition to decreased GFR (Glomerular Filtration Rate), carbon dioxide, and chloride levels. A nursing aide also determined the patient's blood pressure was abnormally low, with a reading of 87/41. Neither the on-duty resident nor the attending physician received notice of the aforementioned BMP results or blood pressure reading. Consequently, the patient developed acute liver and renal failure, coagulopathy and hepatic encephalopathy.

During Respondent's deposition she stated that she knew she contacted the patient's attending physician to inform him of the BMP results because it was her habit and custom to call a

physician if any test yielded abnormal or critical findings. However, Respondent also stated that she did not specifically remember calling the attending physician on this particular occasion. The physician's deposition testimony contradicted Respondent's assertion as he stated that he was not contacted by Respondent regarding the patient's abnormal BMP results, although records maintained by the physician's answering service show that Respondent attempted to contact him at 11:30 p.m. on July 27th, 2007. It is not clear what the purpose of the call had been because Respondent did not document the call in her notes. As a result, the nurse who succeeded Respondent's shift was unaware that Respondent's attempt to contact the attending physician was not successful and that he still needed to be notified of the BMP results.

In addition to Respondent's failure to effectively report the patient's BMP results and record her efforts to do so, Respondent also failed to recognize the clinical significance of those results as evidenced by her failure to make additional attempts to contact the attending physician or on-duty resident once an unreasonable amount of time had lapsed since her alleged initial attempt to do so. Furthermore, her notes indicated that, "no significant findings," were observed during her shift. The attending physician only became aware of the patient's abnormal

BMP results around 5:00 p.m. on July 28, 2007, at which point he determined that the patient needed to be transferred to an intensive care unit. The patient ultimately suffered a permanent brain injury and required a liver transplant.

The Board finds that Respondent's July 27, 2007 failure to recognize critical laboratory values, report those values to the attending physician, and document her efforts to do so constitutes repeated acts of negligence, engaging in professional misconduct and failing to comply with the Board's record keeping rule in violation of N.J.S.A. 45:1-21(d), (e) and (h). The Board having reviewed this matter, and having considered the nature of the above conduct, and the parties desiring to resolve this matter, and the Board having determined that the within Order is sufficiently protective of the public health, safety and welfare, in lieu of further proceedings, and for other good cause shown;

IT IS on this 12 day of August, 2014

HEREBY ORDERED AND AGREED that:

1. Respondent is hereby reprimanded for the violations outlined above.

2. Respondent shall fully attend and provide proof of successful completion of a Board-approved course on critical thinking and interpreting laboratory values to include a clear

understanding of her nursing roles when caring for a patient with metabolic acidosis. Respondent shall submit proof of successful completion to the Board within three (3) months following the entry of this Consent Order. "Successful completion" means that Respondent has fully attended live sessions of the course, fully participated, and received a final evaluation of an unconditional pass. Respondent shall be entirely responsible for any and all costs or expenses relating to the course. The required course is in addition to Respondent's obligation to complete continuing nursing education.

3. Respondent shall obey all the laws of the State of New Jersey, the United States and their political subdivisions as well as all regulations, rules or laws pertaining to the practice of nursing in the State or jurisdiction in which she practices nursing. Respondent shall also obey all policies of the facility in which she practices nursing.

4. Any deviation from the terms of this Order without the prior written consent of the Board shall constitute a failure to comply with the terms of this Order. Upon receipt of any reliable information indicating that Respondent has violated any term of this Order, Respondent's license may be automatically suspended by the Board until further Order of the Board. Within

fifteen days following receipt of such notice, Respondent may request a hearing to contest the entry of such an Order. At any such hearing, the sole issue shall be whether any of the information received was materially false. In addition, the Board reserves the right to bring further disciplinary action upon receipt of any new information.

NEW JERSEY STATE BOARD OF NURSING

By: _____
Patricia Murphy, PhD, APN
Board President

I have read and understand the within Consent Order and agree to be bound by its terms.

_____
Angeline T. Chua, R.N.
License # 26NR06502600

Consent as to form and entry.

_____
Anthony M. Tracy, Esq.
Attorney for Angeline T. Chua, R.N.
Date: August 11 2014